U.S. – Mexico Bi-national Demand Reduction Policy Meeting
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[As Prepared]

Welcome to the 8th Bi-National Drug Demand Reduction Policy Meeting. We are glad to have you all here. I would like to start by thanking our hosts, the U.S. State Department, for the use of these great facilities.

This year we have high expectations from the series of panel discussions and breakout sessions that CONADIC and my staff have put together. But before we get into that, let me tell you a bit about why I think we are here.

Before accepting President Obama's offer to be the Nation's drug policy director, I'd spent my entire professional career as a cop. I served in law enforcement for 37 years, with four different police departments in three different states. In 1971, one year before I began my law enforcement career, then-President Nixon held a press conference declaring drugs "public enemy number one." That statement marked the beginning of a government-led "War on Drugs" that would last most of the next four decades.

Over the course of my career, from beat cop in St. Petersburg to police chief in Seattle, I learned an immeasurable amount about the damage drug abuse does to the fabric of our society – and about the terrible toll it takes on individuals, families, and communities across this country. I'll never forget the rage and despair I felt during one undercover operation where I saw a drug dealer take a hit of marijuana – and then blow the smoke in the face of his young son.

But law enforcement didn't teach me everything there was to know about drugs, because ten years ago, if you'd asked me what was wrong with drug addicts, I'd have told you, 'They need to get a spine.' I thought, like a lot of people do, that drug addiction was primarily an incredible moral failing, and that the cure was a simple matter of willpower, of addicts finding the resolve to stop using drugs.

It was during my time as police chief in Seattle that my thinking about drug addiction began to change. Not overnight, but gradually, as I visited homeless shelters, sat on panels with people steeped in the latest research, and spent time at an emergency service center that we established in downtown Seattle, I began to learn about addiction as a disease. It's a process of education that continues to this day. So what have I learned – what ***do*** we know about drug addiction?

As I've said, we know that addiction is a disease. And it's not just a disease, but it's often a chronic, recurring disease. Close to 7 million Americans, or nearly one out of

every 43 people in the country, exhibit the diagnostic criteria for illicit drug use or dependence. We know that prevention works, because just like with high blood pressure, the best way to beat addiction is to never get it at all. We know that addiction strikes the young hardest – people are most susceptible between the ages of 12 to 20 – and we know that if you aren't an addict by the time you celebrate your 20th birthday, you will likely never become one.

Finally, we know that this disease is treatable, even with the most addictive drugs. Methamphetamine addiction was once thought to be incurable – but we now know that recovery rates for meth users who enter treatment are comparable to those for users of similar drugs. Key discoveries about the safety and efficacy of medications such as buprenorphine have helped thousands of heroin users reduce their craving for opiates.

As we've gained a better understanding of addiction as a disease, it's become increasingly clear that the metaphor and philosophy of a "War on Drugs" is flawed. It's been said that if the only tool in your belt is a hammer, then every problem begins to look like a nail – and today, 38 years after Nixon declared war against drugs and the drug culture, it's time to adopt a different approach. Law enforcement will always have a vital role in combating the illegal production, transport, sale and abuse of drugs, but we've acquired many more effective tools than we once had, and it's time we made full use of them as well.

Ending the war on drugs is the easy part. But we can't just declare victory and go home, and here are a few reasons why we can't:

- Deaths from drug overdoses nationally, including overdoses from prescription drugs, recently surpassed gunshot wounds as the number two cause of accidental deaths, behind only motor vehicle accidents.

- Young adults between the ages of 18 and 25 have the highest rates of current drug use – nearly 20 percent reported drug use in 2007, and in the same year, an estimated 2.7 million Americans aged 12 or older used an illicit drug for the first time.

- A 29 percent decline in youth drug use that began in 1997 has ended, and I'm particularly concerned about some other indicators that young people's attitudes toward drugs are softening. Kids today aren't as concerned about the dangers of drugs as kids were 10 years ago, and there is reliable data showing that this kind of softening is often a precursor to an uptick in drug use.

- A recent national roadside survey by the National Traffic Safety Administration for the first time measured the prevalence of drugged driving. The study found that among nighttime weekend drivers, more than 16 percent tested positive for illegal or prescription drugs or over-the-counter medications. Of this group, more than 14 percent were found to have consumed drugs within four hours of being tested.

Ending the war on drugs doesn't mean wishing these very real and very urgent problems away. Nor does it mean conceding defeat. It means that it's time to rethink our strategy. It's time to recognize drug abuse and addiction for what it is – not just a law enforcement issue, but a very complex and dynamic issue of public health, one that demands a systematic, comprehensive and evidence-based approach if we are going to be equal to the task.

So you can see why I am so excited about the meeting that is taking place this week.

Over the next few days, we will talk about some of the ways we can collaborate on drug abuse education and prevention research. The importance of drug-prevention programs has long been recognized, and there is no shortage of prevention programs, on a small-scale. These programs have typically been run out of schools, but also by parent groups, healthcare providers and police, and there have been other stand-alone prevention efforts, like drug-free workplaces and alcohol-keg registration programs.

One way to maximize this profusion of small, independent, short-term efforts would be to better align and incorporate their important work, because there is a large body of research suggesting that the most effective prevention programs are part of coordinated "continuing prevention" systems. These prevention systems would provide repeated and targeted interventions throughout the high-risk years between the ages of 12 and 20. They cannot be condensed into 10-minute classroom presentations. They must bring to bear multiple sources of influence on adolescents, including parents, schools, police, healthcare providers, peers and other members of the community.

The lack of coordinated prevention efforts at the community level has largely been an unfortunate consequence of a funding process at the federal level that is uncoordinated, and one of my priorities will be promoting blended funding streams among Federal agencies that will encourage communities to prepare for and adopt comprehensive prevention programs like those I've just described. In the President's FY2011 Budget request to our congress, we asked for $435.2 million to fund research into the effectiveness of drug prevention, and $238 million to support school based prevention programs.

For FY2011, we also asked for $85 million for grants to Drug-Free Communities coalitions to assist their vital work in preventing and reducing youth substance use. This week, you are going to hear from some of our local drug free community representatives, and we hope we can exchange ideas about how to improve our program here in the U.S., and how you can use these ideas in some of your communities in Mexico. The U.S. State Department already funds similar coalitions in Mexico and many other countries but we can improve.

DFC is a highly competitive grant program. Applications are reviewed by dedicated community leaders who have already received grants, and who know firsthand what works best at the community level. Each grantee identifies and prioritizes the problems

unique to their community and decides how best to mobilize their own community to respond to those problems. They define their goals and objectives in a comprehensive strategic plan to prevent and reduce youth substance use by focusing on changing the entire community environment.

As effective as prevention programs can be, they won't prevent every young person from experimenting with drugs. And all too often, youthful experimentation becomes that first step down the troubled path of addiction. Here's where we can apply a lesson learned from other public health crises – that when prevention falls short, the next priority must be containment, and when the goal is to contain a crisis, responding at the first sign of trouble is absolutely essential.

One way to ensure we can better recognize and act on the early signs of drug abuse is by encouraging health care professionals to identify at-risk individuals and to intervene before the problem worsens. The majority of Americans see a health-care provider at least once a year, and the expertise of our nation's doctors and nurses in recognizing health-related signs of drug abuse can serve as a valuable early-warning system.

The U.S. Government has established a demonstration program called "Screening, Brief Intervention, Referral and Treatment" (SBIRT) to perform drug abuse screening and to provide brief interventions in hospitals, primary care settings, colleges, and one tribal council. As of February, 2008, more than 600,000 patients in the United States have been screened as part of the SBIRT demonstration program, and over 22 percent of them screened positive.

Of those 22 percent, 16 percent received a brief intervention, about 4 percent received brief drug treatment, and about another 4 percent were referred to specialized treatment programs. A six month follow-up review of patients showed significant declines in substance abuse after these brief interventions. This approach is very cost-effective, and since January of 2007, doctors can bill Medicaid for drug and alcohol treatment using codes approved by the Centers for Medicare and Medicaid Services. In the 2011 budget request, President Obama asked for $41 million for this program, more than 25% higher than 2010.

Even the best prevention and diversion programs don't have a 100% success rate, and young people who continue to use drugs after their peers have stopped experimenting are much more likely to go on to become addicts - the most difficult group to reach and to help.

If we're going to deal effectively with the drug problem, we must find ways to reach these people and change their behavior. While there's no such thing as a magic pill, there are many effective treatments for addiction, and we know that treatment offers the best hope of changing the behavior of people with substance abuse problems.

We've learned over the years that it's not enough to warn addicts about the consequences of their behavior, because they don't think the way you and I do - addiction actually

changes how the brain works. Nor is the answer simply throwing addicts in jail and hoping they dry out – since 1994 it has been true that upon their release from prison, two-thirds of drug abusers are rearrested, and virtually all relapse quickly to drug abuse.

Increasing the number of "treatment programs" alone isn't a solution either – there are already 12,000 specialty addiction treatment programs, primarily funded through Federal block grants. But many of these are small, independent outfits that operate outside of the contemporary healthcare system – fewer than half employ even one physician. What's needed is a true treatment ***system***, one that makes use of evidence-based clinical practices and is well-integrated with the larger healthcare system.

The more than 9 million people who are either behind bars in U.S. prisons and jails or in community corrections programs (including parole, probation, pre-trial release or pre-sentencing release) are another dramatically underserved population when it comes to addiction treatment and we have a panel on Wednesday where I hope we can discuss some collaborative and innovative criminal justice initiatives related to courts, law enforcement practices, community collaboration and alternatives to incarceration. Given the dearth of treatment available behind bars, it's not surprising that more than 50 percent of the estimated 700,000 U.S. citizens who reenter society each year from State and Federal prisons meet the criteria for addiction.

We have to change our old, outdated attitudes about drug use and addiction within the criminal justice system by making treatment available to the incarcerated. This doesn't mean that people who break the law shouldn't be punished. But while they're in custody, we ought to examine whether a drug problem is the central reason they've committed crimes. If it is, we should seize the opportunity to treat that problem while we can.

The Obama Administration's FY2011 Budget also calls for $50 million for the Second Chance Act, which emphasizes rehabilitation rather than parole.

Now, despite all of the changes I've laid out today, there's a crucial truth that we cannot forget: in any serious effort to deal with this country's drug problem, law enforcement ***must*** play a vital role. Nothing that I've described should be taken as a diminishing of that role's importance – instead what is needed moving forward is to make sure we aren't asking law enforcement to shoulder the entire burden alone – not only because that burden is so great, but also because, let's face it, the brave men and women of both of our nations who wear the badge have plenty of responsibilities on their plate already.

I know I don't have to tell anyone here that Mexico is in a vicious fight with ruthless and exceedingly wealthy trafficking organizations, and the threat is in great measure driven by money coming from the U.S. consumption of illegal drugs. I've taken two trips to Mexico since being confirmed in May, and I've seen firsthand evidence of the courageous stand President Calderon has taken against the cartels' operations within Mexico's borders. ONDCP is developing a balanced strategy to help Mexico by reducing U.S. demand for drugs, and stemming the flow of guns and money from the U.S. into Mexico is also a top priority.

When President Obama asked me to serve as drug czar, he explained that one of my first duties would be to craft his first National Drug Control Strategy, an annual planning document focused on the nature and scope of the challenges we are facing, as well as the policies and programs that will have the most meaningful and measurable impact.

His instruction to me was, "I want you to go around the country and sit down with people on every side of this issue to get their thoughts and their input on what the National Drug Control Strategy should look like."

So that's what I've been doing. I've traveled across the country to meet with experts and practitioners in law enforcement, the prevention and treatment communities, as well as with addicts, their families, and recovered addicts, to hear their thoughts about how to craft a National Drug Control Strategy that draws on the strengths, expertise and insights each of these partners brings to the table. These roundtable discussions have been incredibly helpful in crafting a national strategy.

We are very fortunate to have distinguished speakers with this morning to open our meeting, including the Secretary of Health for each of our countries and Mexico's First Lady, Mrs. Margarita Zavala. Never before has this type of a conference had this much support from both presidential administrations. But the real experts are sitting in the seats next to you, and I look forward to a truly open dialogue this week.

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